SAINT ANTHONY HOSPITAL

Date: _____.

Mr(s) _____.

The following documentation is required in order to apply for Financial Assistance with Saint Anthony Hospital. Please return all documents that apply to you to the address below within the next 30 days so that we may determine your eligibility.

- **Identification with current proof of state of Illinois residency.**
  Driver's license, State ID, Lease agreement, mortgage statement or Utility bill.
- **The balance is not a co-pay or deductible fee.**
- **Proof of income from all working persons in the household:**
  A complete copy of the previous year's income tax returns with W2.
  Unemployment benefit checks (If recently unemployed)
  Last 3 check stubs (***patient and spouse if applicable***).
  Social Security benefits letter (if applicable)
- **Letter of support (preferably notarized) if not employed.**
- **Proof of dependents.** (if not listed on tax forms)
  Birth Certificate, Social Security card or Identification.

- ***Additional documentation may be required upon application review.***

If you have any questions please feel free to contact us at
(773) 484-4800 from 7:00 AM to 5:00 PM Monday thru Friday.

PLEASE MAIL ALL THE DOCUMENTATION TO:
SAINT ANTHONY HOSPITAL
P.O. BOX 809109
CHICAGO, ILLINOIS 60680-9109
ATTN: CUSTOMER SERVICE REP.
SUBMIT VIA FAX TO (773) 484-4806

PLEASE NOTE: ***THIS APPLICATION IS FOR HOSPITAL & SAH EMPLOYED PHYSCIANS SERVICES.***

Saint Anthony Hospital
Financial Assistance Application

Important: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE: Completing this application will help Saint Anthony Hospital determine if you can receive free or discounted services or other public programs that can help pay for your healthcare. Please submit this application to the hospital.

IF YOU ARE UNINSURED, A SOCIAL SECURITY NUMBER IS NOT REQUIRED TO QUALIFY FOR FREE OR DISCOUNTED CARE. However, a Social Security Number is required for some public programs, including Medicaid. Providing a Social Security Number is not required but will help the hospital determine whether you qualify for any public programs.

Please complete this form and submit it to the hospital in person, by mail, by electronic mail, or by fax to apply for free or discounted care within 30 days. ***You will receive a final determination letter via mail within 30 days upon receipt of all required documents.***

Patient acknowledges that he or she has made a good faith effort to provide all information requested in the application to assist the hospital in determining whether the patient is eligible for financial assistance.

Internal Use Only:

Application Date: _____ MRN: _____ Account Balance: $ _____

Visit ID Numbers: _____

Approved %: _____ Fam/Unit: _____ $ _____ Denied: _____

Reason: _____

Patient Information:

Patient Name: _____ **Phone Number: Home:** _____

Patient Date of Birth: _____ **Phone Number: Cell:** _____

Patient Address: _____

Patient an Illinois resident at time of service? (circle one) **YES** **NO**

Patient involved in an alleged accident? (circle one) **YES** **NO**

Patient victim of an alleged crime? (circle one) **YES** **NO**

Patient Social Security Number (not required if uninsured): _____

Patient email address (optional): _____

If applicable: Guarantor Information (if patient is a minor or spouse/partner is responsible for patient):

Guarantor Name: _____

Guarantor Address: _____

Guarantor telephone or cell phone number: _____

Family Household Information:

Number of persons in the patient's family/household: _____

Number of persons who are dependent of the patient: _____

List the ages of the dependents in the household:

Dependents		Age
Dependent	1	
Dependent	2	
Dependent	3	
Dependent	4	
Dependent	5	
Dependent	6	

Patient's Family Income and Employment Information:

Patient – are you employed? (circle one) **YES** **NO**

If yes, please complete the following:

Name of employer: _____

Address of employer: _____

Telephone number of employer: _____

Spouse of patient – are you employed? (circle one) **YES** **NO**

If yes, please complete the following:

Name of employer: _____

Address of employer: _____

Telephone number of employer: _____

If the patient is a minor, is the parent or guardian of the minor employed? (circle one) **YES** **NO**

If yes, please complete the following:

Name of employer: _____

Address of employer: _____

Telephone number of employer: _____

If the patient is a minor, is the other parent or guardian of the minor employed? (circle one) **YES** **NO**

If yes, please complete the following:

Name of employer: _____

Address of employer: _____

Telephone number of employer: _____

Marital status of the patient (please circle one):

Single **Married** **Widowed** **Separated*** **Divorced***

***If the patient is separated or divorced, is the financial responsibility for medical care set forth in the dissolution agreement or court order?** (circle one) **YES** **NO**

Gross monthly family income:

$	Total household employment income (including self employed)
$	Unemployment compensation
$	Social Security
$	Social Security Disability
$	Veterans' pension
$	Veterans' disability
$	Private disability
$	Workers' Compensation
$	Temporary Assistance for Needy Families
$	Retirement Income
$	Child Support, alimony or other spousal support
$	Other Income
$	Total gross monthly family income

Please provide documentation of the following:

Paycheck stubs (last 4)
Benefit statements
Award letters
Court orders
Federal tax returns
Other documentation in support of income

Are you enrolled in any of the following? (circle all that apply)

Women, Infants and Children Nutrition Program (WIC)
Supplemental Nutrition Assistance Program (SNAP)
Illinois Free Lunch and Breakfast Program
Low Income Home Energy Assistance Program (LIHEAP)
Any community-based program that provides assess to medical care based on low-income financial status
Receipt of grant assistance for medical services
Temporary Assistance for Needy Families (TANF)
IHDA's Rental Housing Support Program

Insurance/Benefit Information:

Does the patient have medical insurance? (circle one) **YES** **NO** **Type of coverage (please circle one):**

Health **Medicare** **Medicare Part D** **Medicare Supplement** **Medicaid** **Veterans'**

Insured Member Name: _____

Insurance Co. Name: _____Phone #: _____

Subscriber ID: _____Group #: _____

I certify that the information in this application is true and correct to the best of my knowledge. I will apply for any state, federal or local assistance for which I may be eligible to help pay for this hospital bill. I understand that the information provided may be verified by the hospital, and I authorize the hospital to contact third parties to verify the accuracy of the information provided in this application. I understand that if I knowingly provide untrue information in this application, I will be ineligible for financial assistance, any financial assistance granted to me may be reversed, and I will be responsible for the payment of the hospital bill.

Patient or applicant's signature: _____ Date: _____

If a patient meets the presumptive eligibility criteria of Saint Anthony Hospital or is otherwise presumptively eligible by virtue of the patient's family income, the patient shall not be required to complete the portions of the application addressing the monthly expense information and estimated expense figures.

PLEASE NOTE: THIS APPLICATION IS FOR HOSPITAL & SAH EMPLOYED PHYSICIAN SERVICES.

LETTER OF SUPPORT

Date _____

Name (s) _____

(Person/s that provides room & board)

_____

Address _____

Phone # (s) _____

I/We provide room & board to : _____

(Patient's Name)

since (date) _____ **to present.**

Relationship to Patient _____

Signature _____

SUBSCRIBED TO AND SWORN before me

this_____day of _____, 20_____

Notaty Public